FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039776

Facility Name: CARMEN MANOR NURSING HOME

Address: 1470 W. CARMEN AVENU (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 878-7000 **Fax #** (773) 878-8335

IDPA ID Number: 363954499001

Date of Initial License for Current Owners: 00/00/75

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Nam : Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period frc 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrat of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY N. DRAZNER, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	113	Intermediate (ICF)	113	41,245	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	36,634	497		37,131	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,634	497		37,131	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, colum 90.03%

D. How many bed-hold days during this year were paid by Public Aid?
821 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight censu Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermedia N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax ye: YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARMEN MANOR NURSING HO # 0039776 Report Period Beginni 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

		Costs Per General Ledger								FOR OHF USE ONLY		
	Operating Expenses	Salary/Wag	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	129,097	23,799	5,000	157,896		157,896		157,896			1
2	Food Purchase		174,206		174,206	(17,885)	156,321	(23)	156,298			2
3	Housekeeping	134,371	20,911		155,282		155,282	536	155,818			3
4	Laundry	28,520	7,981		36,501		36,501		36,501			4
5	Heat and Other Utilities			100,707	100,707		100,707	1,903	102,610			5
6	Maintenance	91,144	21,811	35,849	148,804		148,804	(3,237)	145,567			6
7	Other (specify):*							21	21			7
8	TOTAL General Services	383,132	248,708	141,556	773,396	(17,885)	755,511	(800)	754,711			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	812,371	19,065	68,591	900,027		900,027	148	900,175			10
10a	Therapy	58,105	1,171	624	59,900		59,900		59,900			10a
11	Activities	55,517	6,793	1,993	64,303		64,303		64,303			11
12	Social Services	100,860		6,274	107,134		107,134		107,134			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Progr	1,026,853	27,029	78,682	1,132,564		1,132,564	148	1,132,712			16
	C. General Administration											
17	Administrative	128,684		65,000	193,684		193,684	21,942	215,626			17
18	Directors Fees											18
19	Professional Services			236,240	236,240	(1,101)	235,139	(159,292)	75,847			19
20	Dues, Fees, Subscriptions & Promotions			38,776	38,776		38,776	(5,132)	33,644			20
21	Clerical & General Office Expen	56,262	21,504	166,264	244,030		244,030	(85,406)	158,624			21
22	Employee Benefits & Payroll Taxes			294,235	294,235	17,885	312,120		312,120			22
23	Inservice Training & Education											23
24	Travel and Seminar			791	791		791	141	932			24
25	Other Admin. Staff Transportation			1,088	1,088		1,088	65	1,153			25
26	Insurance-Prop.Liab.Malpractice			80,955	80,955		80,955	623	81,578			26
27	Other (specify):*							23,447	23,447			27
28	TOTAL General Administratio	184,946	21,504	883,349	1,089,799	16,784	1,106,583	(203,612)	902,971			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,594,931	297,241	1,103,587	2,995,759	(1,101)	2,994,658	(204,264)	2,790,394			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceed
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			50,131	50,131		50,131	19,236	69,367			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,380	16,380		16,380	30,707	47,087			32
33	Real Estate Taxes					1,101	1,101	110,899	112,000			33
34	Rent-Facility & Grounds			241,000	241,000		241,000	(241,000)				34
35	Rent-Equipment & Vehicles			8,085	8,085		8,085	773	8,858			35
36	Other (specify):*											36
37	TOTAL Ownership			315,596	315,596	1,101	316,697	(79,385)	237,312			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transpor											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,867	61,867		61,867		61,867			42
43	Other (specify):*	25,806			25,806		25,806	(25,806)				43
44	TOTAL Special Cost Center	25,806		61,867	87,673		87,673	(25,806)	61,867			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,620,737	297,241	1,481,050	3,399,028		3,399,028	(309,455)	3,089,573			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Nu CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,193	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(185)	21		18
19	Entertainment				19
20	Contributions	(3,150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(135,567)	21		24
25	Fund Raising, Advertising and Promotional	(2,999)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,667)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(47,228)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (188,626)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not a general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(120,829)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35**	$ (120,829)		36
37	**TOTAL ADJUSTMENTS (A) and (sum of SUBTOTALS**	$ (309,455)		37

***These costs are only allowable if they are necessary to meet mir licensing standards. Attach a schedule detailing the items inclu on these lines.**

C. Are the following expenses included in Sections A to D of page and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
CARMEN MANOR NURSING HOME
ID# 0039776
Report Period Beginning: 01/01/01
Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Repairs & Maintenance	$ (5,707)	6	1
2	MARKETING SALARIES	(25,806)	43	2
3	MARKETING CONSULTANT	(2,000)	21	3
4	CHARITABLE CONTRIBUTION	(128)	20	4
5	C.O.P.E. DUES IL C L T C	(2,383)	20	5
6	MISC INCOME	(33)	21	6
7	TRUST FEES-BUILD PARTNERSHIP	(175)	21	7
8	LEGAL-UNIDENTIFIABLE	(99)	19	8
9	NON-ALLOWABLE R/E TAX EXP.	(1,011)	33	9
10	NON-ALLOWABLE ACCOUNTING	(5,000)	19	10
11	STATE OF IL-UNCLAIMED PROPERTY	(1,121)	21	11
12	NON-ALLOWABLE SEMINARS	(299)	24	12
13	ANNUAL FEES-BUILDING	(175)	20	13
14	KEYMAN INSURANCE-BUILDING	(451)	22	14
15	ACCOUNTING-BUILDING PRTNSHIP	(1,450)	19	15
16	INSURANCE EXP-BUILDING	(185)	22	16
17	SRT-BULDING PARTNERSHIP	(1,205)	21	17
18				18
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Summary A

Facility Name & ID Nu CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7	
1	Dietary													1
2	Food Purchase	(23)											(23)	2
3	Housekeeping			536									536	3
4	Laundry													4
5	Heat and Other Utilities			872		1,031							1,903	5
6	Maintenance	(5,707)		2,011		459							(3,237)	6
7	Other (specify):*					21							21	7
8	**TOTAL General Services**	(5,730)		3,419		1,511							(800)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Record			148									148	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Pr**			148									148	16
	C. General Administration													
17	Administrative			43,147	(21,600)	395							21,942	17
18	Directors Fees													18
19	Professional Services	(6,549)	1,450	(154,763)	286	284							(159,292)	19
20	Fees, Subscriptions & Promo	(5,685)	175	329	36	13							(5,132)	20
21	Clerical & General Office Ex	(145,103)	1,380	58,212	30	75							(85,406)	21
22	Employee Benefits & Payroll	(636)	636											22
23	Inservice Training & Educati													23
24	Travel and Seminar	(299)		440									141	24
25	Other Admin. Staff Transport			65									65	25
26	Insurance-Prop.Liab.Malprac			541		82							623	26
27	Other (specify):*			21,969	1,478								23,447	27
28	**TOTAL General Administr**	(158,272)	3,641	(30,060)	(19,770)	849							(203,612)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(164,002)	3,641	(26,493)	(19,770)	2,360							(204,264)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
	D. Ownership												(to Sch V, col.7)	
30	Depreciation	2,193	11,824	4,119	113	987							19,236	30
31	Amortization of Pre-Op. & Org													31
32	Interest		28,664	209		1,834							30,707	32
33	Real Estate Taxes	(1,011)	110,547			1,363							110,899	33
34	Rent-Facility & Grounds		(241,000)	7,773		(7,773)							(241,000)	34
35	Rent-Equipment & Vehicles			773									773	35
36	Other (specify):*													36
37	**TOTAL Ownership**	1,182	(89,965)	12,874	113	(3,589)							(79,385)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transport													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(25,806)											(25,806)	43
44	**TOTAL Special Cost Centers**	(25,806)											(25,806)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(188,626)	(86,324)	(13,619)	(19,657)	(1,229)							(309,455)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessa

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cos of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	INTEREST INCOME	$ 881	CARMEN MANOR BUILDING PARTNERSHIP		$	$ (881)	1
2	V	34	RENTAL INCOME	241,000	CARMEN MANOR BUILDING PARTNERSHIP			(241,000)	2
3	V	22	INSURANCE EXPENSE		CARMEN MANOR BUILDING PARTNERSHIP		185	185	3
4	V	32	INTEREST EXP. - MORTGAGE		CARMEN MANOR BUILDING PARTNERSHIP		29,545	29,545	4
5	V	30	DEPRECIATION EXP		CARMEN MANOR BUILDING PARTNERSHIP		11,824	11,824	5
6	V	33	REAL ESTATE TAXES		CARMEN MANOR BUILDING PARTNERSHIP		110,547	110,547	6
7	V	21	TRUST FEES		CARMEN MANOR BUILDING PARTNERSHIP		175	175	7
8	V	20	ANNUAL FEES		CARMEN MANOR BUILDING PARTNERSHIP		175	175	8
9	V	22	KEYMAN INSURANCE		CARMEN MANOR BUILDING PARTNERSHIP		451	451	9
10	V	19	ACCOUNTING		CARMEN MANOR BUILDING PARTNERSHIP		1,450	1,450	10
11	V	21	REPLACEMENT TAX		CARMEN MANOR BUILDING PARTNERSHIP		1,205	1,205	11
12	V								12
13	V								13
14	Total			$ 241,881			$ 155,557	$ * (86,324)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 536	$ 536	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	872	872	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,011	2,011	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	148	148	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	39,815	39,815	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,177	1,177	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	329	329	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	58,212	58,212	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	440	440	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	65	65	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	541	541	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	21,969	21,969	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	4,119	4,119	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	209	209	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	7,773	7,773	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	773	773	30
31	V	19	HOME OFFICE	155,940	MANAGCARE, INC.	100.00%		(155,940)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	3,332	3,332	32
33	V	17	ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%			33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 155,940			$ 142,321	$ * (13,619)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 43,400	$ 43,400	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	286	286	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	36	36	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	30	30	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,478	1,478	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	113	113	20
21	V								21
22	V	17	MANAGEMENT FEES	65,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(65,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 65,000			$ 45,343	$ * (19,657)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,031	$ 1,031	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		459	459	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		21	21	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		395	395	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		284	284	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		13	13	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		75	75	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		82	82	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		987	987	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		1,834	1,834	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		1,363	1,363	25
26	V	34	RENT	7,773	MAZEL MANAGEMENT			(7,773)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,773			$ 6,544	$ * (1,229)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Begi 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HC # 0039776 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work					
					Compensation Received	Week Devoted to this		Compensation Include		Schedule V.	
				Ownership	From Other	Facility and % of Tota		in Costs for this		Line &	
						Work Week		Reporting Period**		Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	YOSEF DAVIS	General Partner	Officer	48.00%	See Attached	10	16.67%	Salary	$ 15,000	17-1	1
2						Allocation from Inter Care			43,400	17-7	2
3	MOSHE DAVIS	Dir of Operations	Administrative	.3985%	See Attached	19.1	47.75%	Salary	64,272	17-1	3
4						Allocation from Managcare			3,332	17-7	4
5	SHOSHANA BRAUN	Shareholder	Clerical	.3985%	See Attached	20.3	60.24%	Salary	17,127	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 143,131		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Numb: CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr: or parent organization costs? (See instruction: YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organiz: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	1,010,160	4	$ 3,472	$	155,940	$ 536	1
2	5	UTILITIES	BOOKEEPING INC.	1,010,160	4	5,647		155,940	872	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	1,010,160	4	13,027		155,940	2,011	3
4	10	NURSING SALARIES	BOOKEEPING INC.	1,010,160	4	956	956	155,940	148	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	1,010,160	4	257,918	257,918	155,940	39,815	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	1,010,160	4	7,622		155,940	1,177	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	1,010,160	4	2,131		155,940	329	7
8	21	CLERICAL AND GENER	BOOKEEPING INC.	1,010,160	4	377,089	309,593	155,940	58,212	8
9	24	SEMINARS	BOOKEEPING INC.	1,010,160	4	2,850		155,940	440	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	1,010,160	4	419		155,940	65	10
11	26	INSURANCE	BOOKEEPING INC.	1,010,160	4	3,506		155,940	541	11
12	27	GEN. ADMIN. EMP. BEN	BOOKEEPING INC.	1,010,160	4	142,315		155,940	21,969	12
13	30	DEPRECIATION	BOOKEEPING INC.	1,010,160	4	26,685		155,940	4,119	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	1,010,160	4	1,357		155,940	209	14
15	34	RENT - BUILDING (REL	BOOKEEPING INC.	1,010,160	4	50,350		155,940	7,773	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	1,010,160	4	5,005		155,940	773	16
17										17
18	17	ADMIN. SALARY - MOS	AVG HRS WORKED	40	4	6,985	6,985	19	3,332	18
19	17	ADMIN. SALARY - JOSH	AVG HRS WORKED	40	4	7,104	7,104			19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,438	$ 582,556		$ 142,321	25

Facility Name & ID Numb: CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr: or parent organization costs? (See instruction: YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organiz: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKI	60	6	$ 260,400	$ 260,400	10	$ 43,400	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKI	60	6	1,715		10	286	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKI	60	6	218		10	36	3
4	21	CLERICAL & GENERA	AVG. HOURS WORKI	60	6	178		10	30	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKI	60	6	8,871		10	1,478	5
6	30	DEPRECIATION	AVG. HOURS WORKI	60	6	678		10	113	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 272,060	$ 260,400		$ 45,343	25

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organiz MAZEL MANAGEMENT
Street Address 3553 W.PETERSON AVE.
City / State / Zip Code CHICAGO, IL. 60659
Phone Number (773) 463-1313
Fax Number (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG.	1,010,160	4	$ 6,681	$	155,940	$ 1,031	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG.	1,010,160	4	2,971	1,747	155,940	459	2
3	7	EMPLOYEE BEN.-R&M	MNGCR. BOOKPNG.	1,010,160	4	134		155,940	21	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG.	1,010,160	4	2,559		155,940	395	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG.	1,010,160	4	1,837		155,940	284	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG.	1,010,160	4	82		155,940	13	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG.	1,010,160	4	489		155,940	75	7
8	26	INSURANCE	MNGCR. BOOKPNG.	1,010,160	4	531		155,940	82	8
9	30	DEPRECIATION	MNGCR. BOOKPNG.	1,010,160	4	6,392		155,940	987	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG.	1,010,160	4	11,883		155,940	1,834	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG.	1,010,160	4	8,830		155,940	1,363	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 42,389	$ 1,747		$ 6,544	25

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of centr or parent organization costs? (See instruction YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cos Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HO # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	VDA		X	MORTGAGE			$	$ 476,980			$ 29,545	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL BANK		X	LINE OF CREDIT		1/16/98	600,000	350,000		5.50%	12,800	6
7												7
8												8
9	TOTAL Facility Related						$ 600,000	$ 826,980			$ 42,345	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							10,811			4,742	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 10,811			$ 4,742	14
15	TOTALS (line 9+line14)						$ 600,000	$ 837,791			$ 47,087	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CARMEN MANOR NURSING HOM # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	PFS-OXFORD PREMIUM INS		X	FINANCING			$	$			$ 2,658	1
2	MANUFACTURERS BANK		X	AUTO FINANCING	272	1/07/00		10,811			922	2
3												3
4	Interest Income-Bldg CO	X									(881)	4
5	Allocation-Mazel Mgmt	X									1,834	5
6	Allocation-Managcare	X									209	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 10,811			$ 4,742	21

Facility Name & ID Nun CARMEN MANOR NURSING HOME # 0039776 Report Period Beginni 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 repo	$	117,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, deta	$	112,899	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,101)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	115,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed	$	1,101	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decisio	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	112,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Ye	1996	109,175	8
	1997	110,581	9
	1998	110,985	10
	1999	110,240	11
	2000	111,536	12

Accrual: 2000 tax bill*1.03=111,536*1.03=$115,000

Allocation from Mazel Management $1,363

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CAL(	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additiona information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARMEN MANOR NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NU 0039776

CONTACT PERSON REGARDING THI Steve Lavenda

TELEPHON (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-304-046-0000	1470 W CARMEN AVE	$ #########	$ 111,536.31
2.	14-08-304-047-0000	1472 W CARMEN AVE	$ 1,011.12	$
3.	SEE ATTACHED	SEE ATTACHED	$ 40,914.95	$ 1,448.28
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ #########	$ 112,984.59

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home servic X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Nu CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1975	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Numl CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1975	1975	$ 667,212	$	35	$	$	$ 664,438	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1975	53,821		20	-		53,821	9
10	Various			1978	2,925		20	-		2,925	10
11	Various			1981	76,511		20	-		76,095	11
12	Various			1982	4,369		20	-		4,369	12
13	Various			1983	13,203		20	-		13,203	13
14	Various			1984	24,013		20	1,244	1,244	23,372	14
15	Various			1985	3,684		20	205	205	3,415	15
16	Various			1986	8,854		20	467	467	7,497	16
17	Various			1987	32,008		20	1,579	1,579	23,242	17
18	Various			1988	6,653		20	289	289	3,939	18
19	Various			1989	27,647		20	1,347	1,347	16,984	19
20	Various			1990	59,077		20	2,954	2,954	32,986	20
21	Various			1991	48,780		20	2,439	2,439	24,605	21
22	Various			1992	35,671		20	1,132	1,132	10,411	22
23	Various			1993	25,032		20	1,251	1,251	10,533	23
24	Various			1994	15,086		20	1,026	1,026	8,100	24
25	Various			1995	110,747		20	5,538	5,538	37,076	25
26	Various			1996	54,815		20	2,741	2,741	16,291	26
27	Various			1997	3,461		20	173	173	822	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numl CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		41,061	2,136		1,759	(377)	25,567	68
69	Financial Statement Depreciation			18,956			(18,956)		69
70	TOTAL (lines 4 thru 69)		$ 1,314,630	$ 21,092		$ 24,144	$ 3,052	$ 1,059,691	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,314,630	$ 21,092		$ 24,144	$ 3,052	$ 1,059,691	1
2	FIRE PUMP	1998	5,542		20	277	277	1,108	2
3	WINDOWS	1998	17,597		20	880	880	3,153	3
4	ELEVATOR IMPROV	1998	3,419		20	171	171	627	4
5	ELEVATOR	1998	4,500		20	225	225	788	5
6	AWNING & PAINTING	1998	4,500		20	225	225	731	6
7	STAIR SAFETY IMPROV	1998	2,860		20	143	143	465	7
8	FIRE DOOR	1998	1,057		20	53	53	163	8
9	LSC & POL	1998	1,645		20	82	82	273	9
10	CALL & PA SYSTEM	1998	2,569		20	128	128	384	10
11	EXHAUST SYSTEM	1998	2,832		20	142	142	509	11
12	SO EXHAUST SYST	1998	1,818		20	91	91	326	12
13	HOOD/EXHAUST FAN	1998			20				13
14	KITCHEN RISER	1998	1,128		20	56	56	201	14
15	ELEVATOR REPAIR	1998	693		20	35	35	105	15
16	ELEVATOR REPAIR	1998	1,000		20	50	50	150	16
17	TV & VIDEO EQUIP	1998	3,330		20				17
18	EXHAUST SYSTEM	1999	1,801		20	90	90	248	18
19	WALLS & DOORS	1999	10,215		20	511	511	1,235	19
20	WALLPAPER	1999	6,172		20	309	309	773	20
21	DOORS	1999	1,580		20	79	79	191	21
22	FLOORING	1999	10,712		20	536	536	1,206	22
23	DOORS	1999	1,249		20	62	62	140	23
24	DOOR	1999	1,050		20	53	53	119	24
25	WINDOW TREATMENTS	1999	6,102		20	305	305	712	25
26	CARPET	1999	7,670		20	384	384	928	26
27	OFFICE REMODELING	1999	47,113		20	2,356	2,356	4,908	27
28	RADIATOR COVERS	1999	2,210		20	111	111	231	28
29	FIRE DOORS	1999	577		20	29	29	63	29
30	LOCKS	1999	638		20	32	32	67	30
31	NRS CALL SYSTEM	1999	797		20	40	40	83	31
32	CCTV SYSTEM	1999	1,323		20	66	66	138	32
33	DOORS	1999	1,977		20	99	99	248	33
34	TOTAL (lines 1 thru 33)		$ 1,470,306	$ 21,092		$ 31,764	$ 10,672	$ 1,079,964	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,470,306	$ 21,092		$ 31,764	$ 10,672	$ 1,079,964	1
2	DOORS	1999	1,785		20	89	89	223	2
3	DOORS	1999	2,546		20	127	127	318	3
4	DOORS	1999	2,088		20	104	104	260	4
5	PAINTING	1999	2,965		20	148	148	358	5
6	FIRE PROTECTION	1999	2,650		20	133	133	321	6
7	EXHAUST SYSTEM	1999	2,524		20	126	126	347	7
8	ACCESS DOOR	1999	723		20	36	36	99	8
9	ELEVATOR REPAIR	1999	2,335		20	117	117	332	9
10	CCTV SYSTEM	1999	2,262		20	113	113	273	10
11	LIGHT FIXTURE	2000	7,339		20	2,348	2,348	3,816	11
12	WINDOW TREATMENT	2000			20				12
13	REMODELING - ECONO	2000	2,403		20	62	62	111	13
14	REMODELING - ECONO	2000	2,182		20	56	56	91	14
15	REMODELING-H. DEPOT	2000	2,422		20	62	62	90	15
16	ELEV REPAIR	2000	2,565		20	66	66	74	16
17	S ELECTRONIC	2000	9,753		20	250	250	385	17
18	OUTDOOR LIGHTING	2000	999		20	50	50	100	18
19	REMODEL	2000	4,016		20	201	201	402	19
20	PEDASTAL REPAIR	2000	2,409		20	120	120	240	20
21	ELECTRICAL	2000	1,390		20	70	70	140	21
22	EMERGENCY UPGRADE	2000	3,694		20	185	185	370	22
23	WINDOW TREATMENT	2000	12,151		20	608	608	1,216	23
24	WATER HEATER	2001	4,400		20	92	92	92	24
25	WATER HEATER	2001	5,356		20	112	112	112	25
26	ELEVATOR REPAIR	2001	1,336		20	6	6	6	26
27	ELEVATOR REPAIR	2001	636		20	16	16	16	27
28	WALK-IN COOLER REPAIR	2001	2,520		20	63	63	63	28
29	WALK-IN COOLER REPAIR	2001	1,215		20	36	36	36	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Num| CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,970	$ 21,092		$ 37,160	$ 16,068	$ 1,089,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985		$ 15,926	$ 828	35	$ 531	$ (297)	$ 8,627	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MANAGCARE-ALLOCATION			1986	17,224	880	20	789	(91)	13,545	9
10	MANAGCARE-ALLOCATION			1988	227	7	20	11	4	151	10
11	MANAGCARE-ALLOCATION			1993	146	-	20	7	7	62	11
12	MANAGCARE-ALLOCATION			1997	1,857	166	20	186	(20)	820	12
13											13
14											14
15											15
16					-						16
17	MAZEL MANAGEMENT-ALLOCATION			1985	93	-	20	-		93	17
18	MAZEL MANAGEMENT-ALLOCATION			1986	1,335	69	20	66	(3)	1,075	18
19	MAZEL MANAGEMENT-ALLOCATION			1987	331	6	20	8	2	325	19
20	MAZEL MANAGEMENT-ALLOCATION			1989	145	3	20	6	3	77	20
21	MAZEL MANAGEMENT-ALLOCATION			1990	233	5	20	12	7	132	21
22	MAZEL MANAGEMENT-ALLOCATION			1991	150	5	20	7	2	73	22
23	MAZEL MANAGEMENT-ALLOCATION			1993	200	6	20	10	4	84	23
24	MAZEL MANAGEMENT-ALLOCATION			1994	338	6	20	17	11	109	24
25	MAZEL MANAGEMENT-ALLOCATION			1995	86	2	20	4	2	28	25
26	MAZEL MANAGEMENT-ALLOCATION			1196	379	6	20	19	13	105	26
27	MAZEL MANAGEMENT-ALLOCATION			1997	556	14	20	28	14	120	27
28	MAZEL MANAGEMENT-ALLOCATION			1998	596	20	20	30	10	110	28
29	MAZEL MANAGEMENT-ALLOCATION			2000	169	4	20	8	4	11	29
30	MAZEL MANAGEMENT-ALLOCATION			2001	334	4	20	8	4	8	30
31											31
32	INTER CARE, LTD- ALLOCATION			2001	736	105	20	12	(93)	12	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Numl CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 41,061	$ 2,136		$ 1,759	$ (417)	$ 25,567	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustmen	Compone Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 224,396	$ 40,258	$ 29,112	$ (11,146)	10	$ 102,192	71
72	Current Year Purchases	13,047	1,787	395	(1,392)	10	395	72
73	Fully Depreciated Assets	244,169	8	8		10	244,136	73
74								74
75	TOTALS	$ 481,612	$ 42,053	$ 29,515	$ (12,538)		$ 346,723	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation	Straight Line Depreciation	7 Adjustmen	Life in Years	Accumulated Depreciation 9	
76		2000 CAMRY	1999	$ 20,600	$ 2,950	$ 2,060	$ (890)	5	$ 4,635	76
77		Allocation-Managcare	1900	7,362	1,077	630	(447)	5	5,025	77
78										78
79										79
80	TOTALS			$ 27,962	$ 4,027	$ 2,690	$ (1,337)		$ 9,660	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicabl	$ 2,166,544	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 67,172	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,365	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,193	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,446,238	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Le N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	LEXUS LS 400,1999	$ 735	$ 8,085	17
18	Allocation-Managcare			773	18
19					19
20					20
21	TOTAL		$ 735	$ 8,858	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ___

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COST (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe bene
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service	Cost	Units	Cost	Allocated)	(Column 2 +	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginni 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,246	$ 51,748	1
2	Cash-Patient Deposits	5,769	5,769	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	765,771	841,418	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,787	121,787	6
7	Other Prepaid Expenses	1,650	1,650	7
8	Accounts Receivable (owners or related p	106,878	131,303	8
9	Other(specify See supplemental schedul			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,005,101	$ 1,153,675	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		709,800	14
15	Leasehold Improvements, at Historical C	298,524	808,713	15
16	Equipment, at Historical Cost	258,226	516,959	16
17	Accumulated Depreciation (book method	(190,580)	(1,448,077)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify See supplemental schedul	57,796	57,796	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 423,966	$ 745,191	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,429,067	$ 1,898,866	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 419,958	$ 526,836	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposit	3,769	16,223	28
29	Short-Term Notes Payable	360,811	360,811	29
30	Accrued Salaries Payable	34,183	34,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,397	6,397	31
32	Accrued Real Estate Taxes(Sch.D		115,000	32
33	Accrued Interest Payable	451	2,836	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	748	748	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	10,000	10,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 836,317	$ 1,073,034	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		476,980	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(sp			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 476,980	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 836,317	$ 1,550,014	46
47	**TOTAL EQUITY(page 18, lin**	$ 592,750	$ 348,852	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,429,067	$ 1,898,866	48

*(See instructions.)

Facility Name & ID Nu CARMEN MANOR NURSING HOME # 0039776 Report Period Beginn 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Repo**	$ 658,812	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of**	$ 658,812	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	24,338	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(90,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (66,062)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 1**	$ 592,750	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,418,439	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus li**	$ 3,418,439	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thr**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (line**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal,**		27
28	See supplemental schedule	4,927	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 an**	$ 4,927	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 2**	$ 3,423,366	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	773,396	31
32	Health Care	1,132,564	32
33	General Administration	1,089,799	33
	B. Capital Expense		
34	Ownership	315,596	34
	C. Ancillary Expense		
35	Special Cost Centers	25,806	35
36	Provider Participation Fee	61,867	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,399,028	40
41	**Income before Income Taxes (line 30 minus line 40)****	24,338	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 r**	$ 24,338	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?ot complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Numb CARMEN MANOR NURSING HOME # 0039776 Report Period Beginnin 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,448	1,480	$ 37,350	$ 25.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,645	1,700	33,027	19.43	3
4	Licensed Practical Nurses	14,167	15,091	262,837	17.42	4
5	Nurse Aides & Orderlies	45,042	46,834	402,345	8.59	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,886	2,216	58,105	26.22	8
9	Activity Director	1,859	1,930	24,465	12.68	9
10	Activity Assistants	4,621	4,814	31,052	6.45	10
11	Social Service Workers	6,246	6,477	100,860	15.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,408	14,317	129,097	9.02	15
16	Dishwashers					16
17	Maintenance Workers	7,963	8,444	91,144	10.79	17
18	Housekeepers	15,366	16,789	134,371	8.00	18
19	Laundry	2,972	3,306	28,520	8.63	19
20	Administrator	1,640	1,888	46,870	24.83	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	81,814	39.33	22
23	Office Manager					23
24	Clerical	4,910	4,992	56,262	11.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,518	4,945	76,812	15.53	31
32	Other Health Care(specify)					32
33	Other(specify)	520	520	25,806	49.63	33
34	TOTAL (lines 1 - 33)	130,291	137,822	$ 1,620,737 *	$ 11.76	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consulta Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 5,000	01-03	35
36	Medical Director	monthly	1,200	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	1,350	52,119	10-03	38
39	Pharmacist Consultant	monthly	600	10-03	39
40	Physical Therapy Consultant	2	113	10a-03	40
41	Occupational Therapy Consul	10	511	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	5,370	1,993	11-03	44
45	Social Service Consultant	115	6,274	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,063	$ 71,842		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	366	11,840	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	366	$ 11,840		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL GOTTESMAN(1/1-1/3	ADMINISTRATOR	0.00%	$ 8,477
MOSHE DAVIS(2/1-3/18/01)	ADMINISTRATOR	.3985%	8,034
ELI GRINSPAN(3/19-12/31/01)	ADMINISTRATOR	0.00%	34,288
YOSEF DAVIS	ADMIN CONSULTANT	48.00%	15,000
ELI TROPPER	ADMIN CONSULTANT	0.00%	6,647
MOSHE DAVIS	ADMIN CONSULTANT	.3985%	56,238
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 128,684

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-InterCare, LTD	$ 65,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 65,000

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothbla	Accounting	$ 26,347
Managcare-Home Office Exp	Bookkeeping	155,940
Personnel Planners	Unemployment Consulta	1,375
Econocare	Purchasing Consultant	2,034
Commitment Consulting	Management Consultant	47,305
See Attached	Legal	2,035
American Express	Compliance Consultant	1,204
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoi		$ 236,241

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,204
Unemployment Compensation Insuran	35,023
FICA Taxes	123,325
Employee Health Insurance	81,424
Employee Meals	17,885
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	3,064
OTHER EMPLOYEE BENEFITS	9,733
EMPLOYEE PENSION	13,340
HOLIDAY EXPENSE	3,122
TOTAL (agree to Schedule V, line 22, col.8)	$ 312,119

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitmer	25,624
Health Care Worker Background (	920
(Indicate # of checks perfo 103)	
LICENSES & PERMITS	2,430
DUES & SUBSCRIPTIONS	4,092
Allocation-Managcare	330
Allocation-Inter Care, Ltd	36
Allocation-Mazel Mgmt	13
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. line 20, col. 8)	$ 33,645

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	492
Allocation-Managcare	440
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 932

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a ur **YES**

(2) Are there any dues to nursing home associations included on the **YES**
If YES, give association name and **IL C L T C-$4,092**

(3) Did the nursing home make political contributions or payments to a politica action organization **YES** If YES, have these costs been properly adjusted out of the cost repc **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed end of the fiscal ye **NO** If YES, what is the capacity **N/A**

(5) Have you properly capitalized all major repairs and equipment **YES**
What was the average life used for new equipment added during **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V **438** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior repo **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback ar **NO**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructic Schedule VI YES NO **X** If YES, please indicate name of the facil IDPH license number of this related party and the date the present owners took over **N/A**

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Dep of Public Aid during this cost report perio **61,867**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Sch for an individual employe **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,885** Has any meal income been offset against related costs? Indicate the amo $

(16) Travel and Transportation

a. Are there costs included for out-of-state tr **NO**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting per **N/A**

c. What percent of all travel expense relates to transportation of nurs **NONE**

d. Have vehicle usage logs been mai **N/A**

e. Are all vehicles stored at the nursing home during the night and all other times when not in us **N/A**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report **N/A**

g. Does the facility transport residents to and from day t NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public a **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attache **N/A** If no, please explain **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost **YES**
Attach invoices and a summary of services for all architect and appraisal fees